

ORIGINAL

REQUEST TO ESTABLISH DOCKET  
(PLEASE TYPE)

Date May 20, 2002

Docket No. 020451-TC

- 1. Division Name/Staff Name Competitive Markets & Enforcement/Isler
- 2. OPR Competitive Markets & Enforcement/Isler
- 3. OCR Office of the General Counsel

4. Suggested Docket Title Cancellation by Florida Public Service Commission of Pay Telephone Certificate No. 4147 Issued to Fernando Ferrarone for Violation of Rule 25-4.0161, F.A.C., Regulatory Assessment Fees, Telecommunications Companies

5. Suggested Docket Mailing List (attach separate sheet if necessary)

- A. Provide NAMES ONLY for regulated companies or ACRONYMS ONLY regulated industries, as shown in Rule 25-22.104, F.A.C.
- B. Provide COMPLETE name and address for all others. (Match representatives to clients.)
  - 1. Parties and their representatives (if any)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Interested Persons and their representatives (if any)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. Check one:

- Documentation is attached.
- Documentation will be provided with recommendation.

I:\PSC\RAR\WP\ESTDKT.

PSC/RAR 10 (Revised 01/96)

DOCUMENT NUMBER-DATE

05330 MAY 20 02

FPSC-COMMISSION CLERK

December 15, 2001

To Whom It May Concern:

Please be notified that Fernando A. Ferrarone deceased on 11/26/01 in Miami-Dade, FL.  
A copy of the death certificate is attached. Thank you for your time.

Sincerely,

*C. A. Ferrarone*

TF349

*C. A. Ferrarone*

2002 MAY 17 AM 9:51  
DIVISION OF  
COMPETITIVE SERVICES

OFFICE of VITAL STATISTICS

CERTIFIED COPY  
CERTIFICATE OF DEATH  
FLORIDA

*1564*

TYPE OR  
PRINT IN  
PERMANENT  
BLACK INK

LOCAL FILE NO.		1. DECEDENT'S NAME			2. SEX	
		FIRST <b>FERNANDO</b>	MIDDLE <b>A.</b>	LAST <b>FERRARONE</b>	Male	
DECEDENT	3. DATE OF DEATH (Month, Day, Year)	4. SOCIAL SECURITY NUMBER		5a. AGE-Last Birthday (years)	5b. UNDER 1 YEAR	5c. UNDER 1 Day
	November 26, 2001	[REDACTED]		63	Months	Days
	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)			8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)	
7.	April 29, 1938	Peru			No	
9a.	9a. PLACE OF DEATH (Check only one; see instructions on other side)				9b. INSIDE CITY LIMITS? (Yes or No)	
9a.	HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				Yes	
9b.d.e.	9c. FACILITY NAME (If not institution, give street and number)			9d. CITY, TOWN, OR LOCATION OF DEATH		9e. COUNTY OF DEATH
9b.d.e.	Cedars Medical Center			Miami		Miami Dade
10.	10a. DECEDENT'S USUAL OCCUPATION		10b. KIND OF BUSINESS/INDUSTRY		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	
	Proprietor		Pest Control		Married	
				12. SURVIVING SPOUSE (If wife, give maiden name)		
				Joan Jenkins		
13.	13a. RESIDENCE - STATE		13b. COUNTY		13c. CITY, TOWN, OR LOCATION	
	Florida		Miami Dade		Miami	
				13d. STREET AND NUMBER		
				16007 S.W. 155 Avenue		
13a.	13a. INSIDE CITY LIMITS? (Yes or No)		13b. ZIP CODE		14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) - No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Specify: Peruvian	
	No		33187		White	
				15. RACE - American Indian, Black, White, etc. Specify:		16. DECEDENT'S EDUCATION (Specify only highest grade completed)
						Elementary/Secondary (0-12)    College (1-4 or 5+) 5+
17.	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Maiden Surname)		
	Amadeo Ferrarone			Aida Flores		
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Carlo Ferrarone				16007 S.W. 155 Avenue, Miami Florida 33187		
20a.	20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		20c. LOCATION - City or Town, State	
	<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Woodlawn Park South		Miami, Florida	
21a.	21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		21b. LICENSE NUMBER (of Licensee)		21c. NAME AND ADDRESS OF FACILITY	
	<i>Mauro Garcia Rodriguez</i>		3688		Caballero Rivero Woodlawn Funeral Home 11655 S.W. 117 Avenue, Miami Florida 33186	
22a.	22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated (Signature and Title)					
	<i>Rafael Crespo, M.D.</i>					
22b.	22b. DATE SIGNED (Mo., Day, Yr)		22c. HOUR OF DEATH		23a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner as stated. (Signature and Title)	
	11/27/01		7:00 A.		<i>Rafael Crespo, M.D.</i>	
22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)				23b. DATE SIGNED (Mo., Day, Yr)		23c. HOUR OF DEATH
24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)				25c. DATE REGISTERED		
Rafael Crespo, M.D. 456 S.W. 8 Street, Miami Florida 33130				NOV 28 2001		
25a. SUBREGISTRAR - SIGNATURE AND DATE		25b. LOCAL REGISTRAR - SIGNATURE		25c. DATE REGISTERED		
<i>Mauro Garcia Rodriguez</i>		<i>Rafael Crespo</i>		NOV 28 2001		
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →						
a. <i>Candida Pulmonary Abscess.</i>						
DUE TO (OR AS A CONSEQUENCE OF):						
b. <i>Septic shock.</i>						
DUE TO (OR AS A CONSEQUENCE OF):						
c.						
d.						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				27a. WAS AN AUTOPSY PERFORMED? (Yes or No)		28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No)
				No		YES
29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? Yes No		30a. IF SURGERY IS MENTIONED IN PART I or II, ENTER CONDITION FOR WHICH IT WAS PERFORMED		30b. DATE OF SURGERY (Mo., Day, Year)		
31. PROBABLE MANNER OF DEATH (Specify) Natural, accident, suicide, homicide, or undetermined.		32a. DATE OF INJURY (Month, Day, Year)		32b. TIME OF INJURY		32c. INJURY AT WORK? (Yes or No)
32e. PLACE OF INJURY - At home, farm, street, factory, etc. (Specify)				32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

BY

*Mauro Garcia Rodriguez*

NOV 29 2001  
State Registrar

WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.

13038205

THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

FLORIDA DEPARTMENT OF

HEALTH

DOH FORM 1564 (10/98)

CERTIFICATION OF VITAL RECORD

**COMPANY IDENTIFICATION**

Printed on 05/20/2002 at 08:19:25 by PJI

Complete Name: Fernando Ferrarone

Mailing Name: Fernando Ferrarone

Company Code: TF349                      FEID Number: 65-0595715

**RAF ACCOUNT FOR THE PERIOD 01/01/2001 THROUGH 12/31/2001**

Reg. Date:	04/28/1995	Inactive Date:	
Service:	PAT - Pay Telephone		
Received:	No RAF Form		
Status:	Pending		
Amended:	No	Extension:	No
Frozen:	No	Comments:	No
Payment Count:	0 Payments Made to Date		
Operating Rev:	\$0.00	Interstate Rev:	\$0.00
RAF Rate:		Net RAF Due:	\$0.00

Assessment	Due	Paid	Owe
RAF	\$0.00	\$0.00	\$0.00
Penalty	\$0.00	\$0.00	\$0.00
Interest	\$0.00	\$0.00	\$0.00
Extension Fee	\$0.00	\$0.00	\$0.00
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Last modification was made on Thursday, December 6, 2001 at 3:16 PM by Jackie Knight

Period covered:	01/01/2001 through 12/31/2001	RAF rate:	
Operating rev:	\$0.00	Gross intrastate rev:	\$0.00
Documents:	Delinquent letter mailed on 02/20/2002		
	RAF form mailed on 12/06/2001		